HJ 16: Moving from institutional care to community based, Assisted Outpatient Treatment-A Collaborative Effort

My Son's Case:

1. At MSH since December 14, 2010 after pleading no contest to 3 felonies and court found our son Guilty But Mentally Ill (unable to form a criminal intent due to mental illness: schizo-affective disorder)

2. He is 27 years old and has been afflicted with a Serious Mental Illness, Shizo-affective disorder, since he was 16. Up until then he played football and wrestled at Capital High School, was a member of the Helena Civil Air Patrol, had plenty of friends, and was a "B" student. However, his mental illness was serious enough he was unable to attend school his Junior Year, and he had to be "home schooled" by the school district.

3. It has taken me until now to speak publically about our experience because I have worked as a provider of children's mental health services for nearly 20 years, and if anyone should have known how to get our son help, I should have. However, it is just not possible to describe the nearly impossible difficulties of trying to navigate our mental health system, especially when your own child is totally incapacitated by a serious mental illness.

4. His mother and I looked everywhere to find help. During this time he had 5 suicide attempts, but was never in trouble with the law until, after turning 24, he experienced a psychotic break that was so severe that he seriously injured 2 people including a sheriff's deputy as his "voices" told him they were going to get him.

5. He was told yesterday he will be considered for release from Montana State Hospital in January 2014 for a total cost of over $630,000.

6. ~~After his release he stands a 60% chance of his parole being revoked.~~

Overview of Sue O'Connell's hjr 16 msh background Sept 2013

- Montana is spending almost $400K in general fund for each GBMI patient, or a total of over $15 ½ million for the 40 GBMI patients at Warm Springs.
- Sue's report doesn't cite a recidivism rate for paroled GBMI patients, but it has been previously reported as approximately 60%.
- However, 46% of MSH admissions are re admission.
- Sue O'Connell's MSH background report also cites that the nearly all of the MSH HB 2 appropriation of $32.2 million FY 14 appropriation is state general fund.
- For individuals that were eligible for Medicaid or SSI Disability while in the community, lose their eligibility when they become patients/inmates in a state institution or are incarcerated.

We can do better, but we'll need to do it together.

The opportunities for improving Forensic Unit Discharge outcomes requires a paradigm shift from custody, control, and treatment to Community Based Assisted Outpatient Treatment (AOT), which the Treatment Advocacy Center: http://www.treatmentadvocacycenter.org/ advocates that states adopt, and the Federal Office of Justice Programs (OJP) has determined that Assisted Outpatient Treatment is an "effective" and evidence-based practice for reducing crime and violence.

The AOT paradigm was initially developed to support successful community based transitions from psychiatric hospitals, but its primary application has been to prevent psychiatric hospitalizations, arrests, homelessness and incarcerations for seriously mentally ill persons thus reducing system costs for both Warm Springs and corrections if it could be applied in Montana

What is Assisted Outpatient Treatment? AOT supports the "success" of consumers in complying with all elements of their treatment and support plans. Montana's statutes gives the district courts the authority to commit a seriously mentally ill individual to a community based facility or program, and SB 11 gives the parole board the authority to require "...participation in a supervised mental health program..." as a condition of parole, and their failure to "comply with the terms of a supervised mental health treatment program" is a basis for being recommitted to Warm Springs.

Although legislative initiatives are essential in supporting this paradigm shift, its adoption and implementation depends on Executive Branch leadership.

5 states are working to minimize their institutional populations including Colorado, Oregon, New Mexico, Minnesota, and Connecticut. The state of Colorado and other states, for example, have developed Forensic Transition Teams to help persons with serious mental illness re-connect to their community upon release from their state hospital's forensic unit or prison to the community on conditional release. Continuous and ongoing Risk Reduction and safety assessments & evaluations drive each participant's ongoing treatment and support plan development and evaluation. Everyone has to be safe for this to work.

Colorado's Forensic Community-Based Services cost & treatment effective outcomes would provide a very useful template for Montana to adapt. Their system supports their ongoing Compliance with medications and sobriety (70-80% co-occurrence), employment, housing and family support needs, transitioning to independence.

Oregon passed and funded their Assisted Outpatient Treatment Bill during their 2013 Session. It's passage involved a lengthy collaboration between their state's mental health authority, community mental health care providers, law enforcement and the judiciary.

However, in Montana the funding levels and rates paid to support community based programs are, in many cases insufficient to sustain community based mental health crisis response teams and crisis response facilities; drop-in centers; & Montana State Mental Health Plan recipients. Rates are insufficient to operate PACT programs with fidelity.

The Executive has an opportunity to engage in a heartfelt dialogue about adopting a parallel philosophy in support of an effective community based mental health system that can materially reduce MSH admissions, lengths of stay, and discharge/parole outcomes.
Our most significant challenge is to re-frame these as opportunities for Montana to invest in the development of a cost and outcome effective community based Forensic transition program guided by fidelity to assisted outpatient treatment principles.

The Bullock administration's active participation is essential as when he, as Attorney General, introduced and implemented the "24/7 Sobriety Program" The 24/7 Sobriety Program which represented a paradigm shift in requiring "those accused of their second or subsequent drunken driving offense to twice daily submit to breathalyzer tests as a condition of their release from jail pending trial. A year later it was determined that 99.7% of those monitored through this program stayed sober. Successfully transitioning seriously mentally ill forensic patients back to the community is considerably more involved, but the same "assisted" principles apply.

The State of Colorado created a joint task force for the study of their behavioral health care system in 2007 and has reduced their state psychiatric hospital utilization by 28%. The state of Oregon's legislature approved and funded their own Assisted Outpatient treatment bill.

However, these successful efforts required:

- A true understanding of their forensic population.
- The funding options available to sustainably fund effective outpatient treatment.
- A strong collaborative relationship between the state mental health authority, community behavioral health care providers, the judiciary, and law enforcement.

We need the opportunity to work with one another, and do our due diligence.

Respectfully submitted,
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